MARYLAND HEALTH CARE COMMISSION

Summary of the Healthcare-Associated Infections (HAI)
Advisory Committee Meeting

July 24, 2013

Committee Members Present
Sara E. Cosgrove, MD, MS
Jacqueline Daley, HBSc, MLT, CIC, CSPDS
Maria E. Eckart, RN, BSN, CIC (conference call)
Elizabeth P. (Libby) Fuss, RN, MS, CIC
Anthony Harris, MD, MPH (conference call)
Emily Heil, PharmD
Andrea Hyatt, CASC (conference call)
Lynne V. Karanfil, RN, MA, CIC (conference call)
Brenda Roup, Ph.D, RN, CIC
Jack Schwartz, JD
Kerri Thom, MD
Lucy Wilson, MD, ScM

Committee Members Absent
Beverly Collins, MD, MBA, MS
Wendy Gary, MHA
Debra Illig, RN, MBA, CLNC
Robert Imhoff
Peggy A. Pass, RN, BSN, MS, CIC
Michael Anne Preas, RN, BSN, CIC
Patricia Swartz, MPH, MS
Renee Webster, RS

Public Attendance
Julie Bryan (conference call)
Mary Clance (conference call)
Carolyn Jackson
Donna Lemmert (conference call)
Rebecca Perlmutter
Katie Richards
Janet Robinson (conference call)
Sheena Siddiqui

Commission Staff
Theressa Lee
Mariam Rahman
Eileen Witherspoon
Carol Christmyer

1. Call to Order

Theressa Lee, Director, Center for Quality Measurement and Reporting, called the meeting to order at 1:00 p.m.

2. Review of Previous Meeting Summary

The minutes of the previous meeting on April 24, 2013 were accepted by the committee with no corrections.

3. Update *Clostridium difficile* Reporting through NHSN

Ms. Witherspoon stated that the *Clostridium difficile* infection reporting began July 1, 2013. The first month of data will be due the end of August. An email with a link to the NHSN training for the CDI module and a FAQ document was sent out to hospitals. This information was sent out in lieu of holding a MHCC sponsored training session. The FAQ document will be updated as questions arise from the hospitals.

4. Discussion on Current CLABSI and Future Audits

Ms. Lee discussed processes that will be put in place to improve future audits including:

- Starting the process early to give hospitals time to compile records
- Having a sign-off document completed at the end of the audit so any issues can be identified at that point
- Involving the hospitals in the information that is sent to NHSN, in the event a consensus cannot be reached on a case

She added that the process can be challenging when a hospital does not agree with the audit findings and the NHSN response. In future audits, Ms. Lee suggested that a letter be sent to the hospital CEO and the IP stating that based on CDC's determination the case should be added or deleted from the system. Dr. Thom and Dr. Cosgrove reiterated that there has to be transparency in the process so everyone is on the same page on what was sent to NHSN. Ms. Fuss noted that NHSN is not consistent in determining cases and different answers can be received for the same case. Dr. Roup mentioned that inter-rater reliability is not very high in NHSN case studies. Ms. Daley mentioned it would be helpful to have a specific person at NHSN assigned to review the Maryland cases. Ms. Lee responded that the Commission will continue to review hospital concerns on a case by case basis.

5. Discussion on MRSA Screening on Admission Articles

Dr. Roup discussed the articles including the need to move away from vertical interventions that are focused on specific pathogens, and targeting horizontal interventions. She mentioned antibiotic stewardship programs as an example of a horizontal intervention. Ms. Fuss stated that the interventions, CHG (chlorhexidine gluconate) bathing and mupirocin decolonization, should have been separated in the articles, but the two were studied together. Dr. Cosgrove noted that if all hospitals began mupirocin decolonization, there would be resistance to mupirocin. Dr. Harris noted that the articles did not say what kind of infections were decreased as the samples were not identified. Dr. Cosgrove and Dr. Thom noted that if active surveillance testing was stopped, the hospitals would not know who was colonized and would not be able to track infection trends.

Dr. Wilson mentioned the 2010 MDRO Collaborative that was underway. An *Acinetobacter* prevalence survey took place. They have been working on CRE and prevention strategies along with surveillance of the infections and estimated prevalence. Currently, CRE is not reportable to the state.

6. Joint Presentation on 2012-2013 HCW Vaccination Rates for Nursing Homes, Assisted Living and Hospitals

Ms. Christmyer reviewed the 2012-2013 HCW influenza vaccination rates for nursing homes and assisted living facilities. Of note, the rates continue to increase for nursing home HCWs. The 2012-2013 statewide average rate is 73.6% up from 65.1% last year. The declination rate has declined from 42.1% in 2010-2011 to 26.4% this year. The vaccination rate exceeds the CDC national estimated rate for HCWs in long term care which is 48.7%. Most nursing homes do not have a mandatory policy in place and do not plan to implement a mandatory policy. Assisted living staff's statewide average vaccination rate saw a slight increase from 48% last year to 50.6% this year. Most of the facilities are providing influenza vaccination onsite (98%) and free of charge to employees (98%); 88% hold educational presentations for staff. Employees must sign a declination form for the majority of facilities and this documentation is kept with the employee records. Over half of the facilities have no strategies in place to ensure compliance with the flu policy or limit the spread of influenza. MHCC provided reminders to the facilities throughout the season on how to promote the vaccination. The facilities were provided with their performance results and the information was published in the Maryland Consumer Guide to Long Term Care. Gold Star Certificates were given by MHCC to 19 facilities with rates above 95%.

Ms. Witherspoon reviewed the 2012-2013 HCW influenza vaccination rates for hospitals. During the 4 years of reporting, the rate has increased from 78.1% in 2009-2010 to 96.4% this year. The declination rate has declined from 12.1% in 2009-2010 to 4.5% in 2012-2013. The number of hospitals with a mandatory vaccination policy has increased from 15 hospitals in 2010-2011 to 37 hospitals this past year. The 7 hospitals with less than 90% vaccination rate do not have a mandatory vaccination policy, but 4 of these hospitals plan to have one in 2014. From the 2012 Infection Prevention and Control Program Annual Survey: all hospitals are providing free influenza vaccination to employees, 45 hospitals require printed documentation of off-site vaccination, and 40 hospitals require physician documentation for medical contraindication. Most hospitals maintain documentation on vaccination status of employees. Of the hospitals that have a mandatory vaccination policy, the majority terminate non-physician staff and suspend physician privileges for noncompliance. According to survey results, 109 employees were terminated, suspended, or resigned in hospitals with mandatory influenza vaccination policies.

7. Review Reporting Requirements for NHSN Healthcare Personnel Influenza Vaccination Module

Ms. Lee reviewed the differences between the MHCC HCW Influenza Vaccination Survey and the NHSN Healthcare Personnel (HCP) Influenza Vaccination Module. Specifically the NHSN module requires all HCP who physically worked in the reporting facility for 1 day or more from October 1, 2013 to March 31, 2014 to be included in the denominator. Ms. Lee asked for feedback on having hospitals complete both the MHCC Survey and the NHSN Module for the first year as there may be different results from the different definitions. She asked if this would be a burden for the hospitals. Dr. Thom indicated that it would be an extra burden and there

appeared to be consensus that requiring both surveys was not a good idea. Ms. Lee said information will be sent out in August to the hospitals with training information and a webinar may be held.

8. Other Business

Ms. Siddiqui reviewed upcoming Maryland Hospital Association events. Ms. Fuss asked for an update on the SSI audit. Ms. Lee stated that Advanta was reviewing the denominator data using the HSCRC Inpatient Discharge Database as a quality check. The audit is expected to take place by the end of the year.

9. Adjournment

The meeting adjourned at 2:40 p.m. The next meeting is scheduled for September 25, 2013.